

22.9%), BRCA 2 in 36 (8.7%), and variants of unknown significance in 77 (18.6%) patients. PARP inhibitors were used sparingly initially due to non availability and later due to high cost.

**Conclusion** The mainstreaming of counselling accelerated the testing in patients, but its effective use in treatment can only be possible through affordable pricing of the drug.

**Disclosures** NO conflict of interest

#### #640 EXPERIENCE OF DEVELOPING A NATIONAL TRAINING CURRICULUM IN GYNAECOLOGICAL ONCOLOGY IN INDIA

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**Introduction/Background** Formal training in Gynaecological Oncology (GO) in India started in 2011 with only one candidate for the degree of MCh at Tata Memorial Hospital, Mumbai. A few other University affiliated hospitals also started MCh program in the following years. The number of trainees were grossly inadequate compared to the large demand for service. The training curriculums at the different institutions were also diverse. It was strongly felt that a national curriculum for this super-speciality training was necessary. This article explores how the national curriculum was developed and implemented for training in GO in India.

**Methodology** The author, a key member of the team of experts assigned to develop the national curriculum, while developing a GO service at a newly built cancer institute also developed a training program to meet the demand for a rapidly increasing service and initiate the creation of the next generation of gynaecological oncologists in India.

**Results** The department of GO at Tata Medical Center, Kolkata (TMCK) started with one consultant in May 2021. Two trainees were recruited through a formal selection process. The structured training program, including theoretical knowledge and practical skills training, was for three years and it was planned to recruit two trainees every year. The training program was remodelled periodically according to the service need at TMCK. The Indian National Board accepted the TMCK curriculum for 3-years post-doctoral course in GO in October 2018. The appraisal system of the TMCK curriculum was changed to an exit examination. The first batch of 6 trainees were recruited in 2019 for four accredited institutions. Currently there are 11 recognised institutes recruiting 18 candidates each year to undergo this training.

**Conclusion** The model adopted in India can be replicated in countries where there is no structured national curriculum in GO.

**Disclosures** None

#### #677 REGIONAL IMPLEMENTATION OF MISMATCH REPAIR DEFICIENCY (MMR) SCREENING MODEL FOR LYNCH SYNDROME IN ENDOMETRIAL CANCER PATIENTS

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**Introduction/Background** Mismatch Repair (MMR) testing for endometrial cancer (EC) patients was recommended by the National Institute for Health and Care Excellence (NICE) October 2020 guidance as a screening tool for Lynch syndrome (LS). The North-East of England regional cancer care alliance implemented this guidance in aims to identify EC patients with suspected LS. This project evaluated the efficacy of MMR screening model via immunohistochemistry (IHC) testing for the MMR markers: MLH1, PMS2, MSH2, and MHS6 by reviewing our experience of implementing this MMR testing for LS screening in EC care.

**Methodology** Retrospective analysis of all newly diagnosed EC patients referred for Multi-Disciplinary Team review from six NHS trusts in the North-East of England and North Cumbria was performed, and we assessed the status and outcome of MMR testing in this cohort.

**Results** The status and outcome of MMR testing were collected and analysed in 202 patients, and it was shown that 97% (195) of the examined population had their MMR status reported. Approximately 73% of eligible patients for MMR testing were shown to be MMR-proficient and therefore did not require further testing. Using this screening model, at least 5% of the eligible EC patients were identified to be at risk for LS and needed referral to specialist clinical genetics service for germline testing.

**Conclusion** In the North-East of England region, MMR screening rate in EC remains over 95%, consistent with our pilot data from the screening project's initial implementation period in 2021. The implementation of this screening model in the region has proven to be effective in identifying EC patients with suspected LS, supporting the importance of this screening model in EC care.

**Disclosures** -

#### #689 GYNAECOLOGICAL ONCOLOGY SERVICES IN INDIA: WHERE DO WE STAND AS HEALTH CARE PROFESSIONALS?

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**Introduction/Background** Providing optimal care for patients with Gynaecological malignancies including screening requires insight into the preferences of the women specially in relation to their health care providers. The aim of this study was to understand the health care preferences of the women in a lower middle income country setting in relation to gynaecological cancers.

**Methodology** Qualitative study with semi-structured interviews was conducted among 30 women attending the Obstetrics and Gynaecology Out Patient Department (OPD) of a tertiary care centre in India. In-depth interviews were conducted until data saturation was achieved. Interviews were transcribed verbatim, coded and analysed thematically. Framework approach was used to summarize the data.

**Results** The age of the study participants ranged between 24 and 63 years. Pivotal themes which emerged from the interviews were physician and nursing staff attitudes, open communication, affordable and easily accessible services and also gender of the treating gynae oncologist. As most of the participants were not aware of the spectrum of gynaecological cancers, a major facilitator was open communication by a

supportive health care provider. Autonomy in selecting options for treatment as per socio-economic status was also a facilitator in return visits. Prolonged waiting period for consultation and the perceived indifference of health care staff in a busy OPD were considered as barriers to information and care seeking. Almost all the participants preferred counselling sessions in the native language. Participants also reportedly preferred a female gynaecologic oncologist over a male gynaecologic oncologist when it came to surgical management of these malignancies.

**Conclusion** The success of gynaecological oncology services in a country comprising both preventive and therapeutic aspects depends on multiple cultural factors. The results of this study may be used to make gynae oncology care more patient centric in order to provide prompt and high quality care.

**Disclosures** The authors have no potential conflict of interest to declare

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#### EVOLUTION OF DEBULKING SURGERIES FOR ADVANCED-STAGE OVARIAN CANCER IN AN ESGO-ACCREDITED DEPARTMENT: A PARADIGM OF CHANGE

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**Introduction/Background** Debulking surgery for advanced-stage ovarian cancer is potentially the most challenging surgical procedure in the context of gynaecological oncological care. Such cases are continuously referred to specialized Units and ESGO accreditation may act attractively for patients and referring departments. Main objective of the present study is to report the evolution of debulking surgeries after the first ESGO accreditation of a Northern Greek Gynaecologic Oncology Unit at the end of 2020.

**Methodology** A prospective observational cohort was performed concerning patients treated with a diagnosis of advanced-stage ovarian cancer. Epidemiological, histopathological and surgical reports of all patients were prospectively recorded in a computerized database, based on the recommendations of ESGO for advanced-stage ovarian cancer surgery. The present study concerns patients treated between 2020–2022. Rate of optimal cytoreduction, primary and interval debulking surgery, histological subtype of patients as well as evolution of number of cases throughout study period were set in the center of our analysis.

**Results** There were overall 98 patients operated during study period, of which 28 in 2020, 33 in 2021 and 37 in 2022. Mean age of patients was 61.8 years. Overall complete cytoreduction rate was 79.5% (78/98 patients). This rate remained stable during the overall period (82.1% vs. 78.8% vs 78.4% respectively, P=NS). Primary debulking surgery rate was 68.4% (67/98 cases), the rate also remaining stable during the overall period (71.4%, 72.3% and 67.6% respectively, P=NS). Rates of complete cytoreduction were comparable between primary cytoreductive and interval debulking surgeries (79.7%

vs. 79.3%, P=NS). The main histopathological diagnosis was high-grade serous carcinoma (66/98 cases, 67.3%). Finally, there was observed an overall 32.4% increase of treated cases between 2020 and 2022.

**Conclusion** ESGO accreditation for individual fellowship lead to significant increase of advanced-stage ovarian cancer patients treated in our Department, with a relative maintenance and upgrade of provided services level.

**Disclosures** Authors have nothing to disclose

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#### GENETIC IMPLICATIONS OF A COMPREHENSIVE CANCER GENOME PROFILING PROGRAMME IN A MONOINSTITUTIONAL STUDY: FOCUS ON GYNECOLOGICAL CANCERS

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**Introduction/Background** Comprehensive cancer genome profiling (CGP) evaluation is recommended at least in academic centres for the identification of actionable somatic mutations in a selected subgroup of cancers. Somatic variants could have a germline correlation. Here, we report the possible genetic implications of a CGP programme in ovarian (OC) and endometrial cancers (EC).

**Methodology** In this monocentric interventional prospective study (ID FPG500, IRB approval 3837), all cancer patients with indication for any molecular assessment were profiled through a CGP (523 genes, TSO500HT, Illumina). Each case was reviewed by a geneticist for the identification of suspected germline variants (both variants related to cancer susceptibility and other actionable genetic conditions). In this abstract, we report data regarding OC and EC.

**Results** From January 2022 to December 2022, 244 EC and 445 OC underwent CGP. 222 (32%) patients were referred to genetic counselling (25% of EC and 36% of OC) for suspected germline variants in 32 and 42 genes, respectively. As expected, for EC, the most common suspected germline variants were mismatch repair genes (MLH1, MSH2, MSH6; 19 variants). For OC, the majority of patients (61%) were referred to geneticist for BRCA1/2 germline evaluation. Data on germinal confirmation are available for 73/222 (33%). 30% and 64% of EC and OC somatic variants were confirmed being of germinal origin, respectively. Interestingly, 3/5 (60%) of EC and 10/36 (28%) of OC confirmed germline variants are in cancer predisposing genes other than Lynch syndrome (MUTYH, LZTR1, BRIP1) and BRCA1/2 genes (MLH1, MSH2, BRIP1, RAD51C, RAD51D, ATM, CHEK2, FANCC, ERCC2), respectively.

**Conclusion** Beside therapeutic and prognostic implications, CGP can identify variants related to hereditary cancer predisposition conditions allowing cascade prevention and identification of affected relatives. Moreover, a CGP could improve the